SECTION FOUR:
Intentional Injury Deaths

Intentional injury includes child deaths designated by death certificate as homicide and suicide, along with other child deaths identified by the Child Fatality Review Program as *Fatal Child Abuse and Neglect deaths. In considering Intentional Injury, note that the term "intentional" does not necessarily describe the mindset of the victim or perpetrator, but indicates only that the circumstances involved harmful, volitional acts.

Manner of Death

Homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to kill is a common element, but is not required for classification as homicide. *Suicide* results from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

Homicides

Homicide was listed as the death certificate manner of death for 73 Missouri children in 2001.

For the purpose of analysis of child deaths and their prevention, homicides are divided into three categories, based on the relationship of the perpetrator to the victim:

(1) ***Fatal Child Abuse and Neglect: Child death resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent.** This includes, but is not longer limited to, children whose deaths were reported as *homicide* by death certificate. In 2001, 54 Missouri children were victims of Fatal Child Abuse and Neglect; of those, 38 were reported by death certificate as homicide.

(2) **Death of a child in which the perpetrator was not in charge of the child.** This most often includes youth homicides, such as gang-related or drug-related shootings and child abductions that culminate in murder. There were 32 such fatalities among Missouri children in 2001:

(3) **Deaths of children in which the perpetrator, not in charge of the child, was engaged in criminal or negligent behavior and the child was not an intended victim.** Examples most often include motor vehicle-related deaths involving drugs, alcohol and other criminal behavior. In 2001, there were three homicide deaths of this type among Missouri children.

Figure 30. Homicides by Age

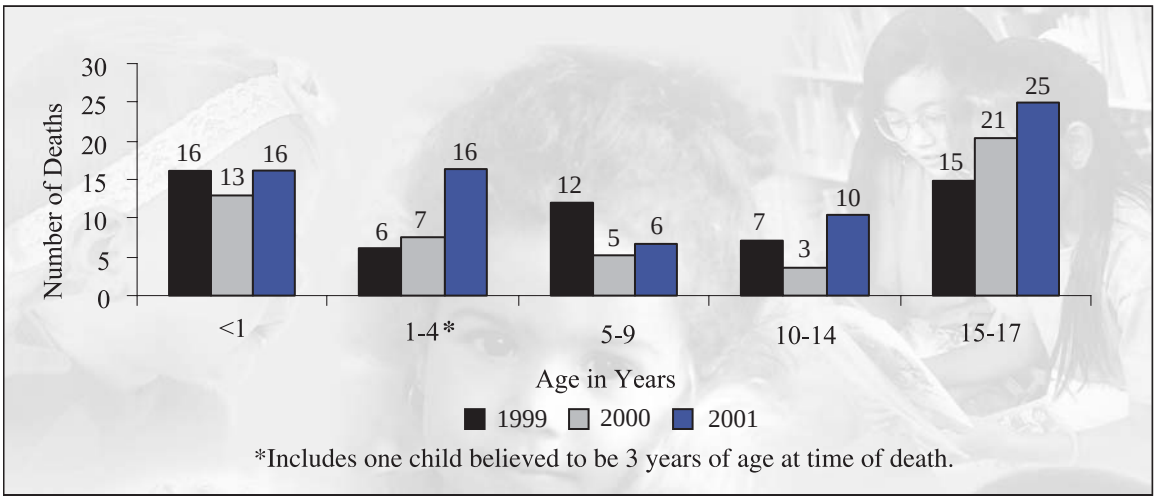
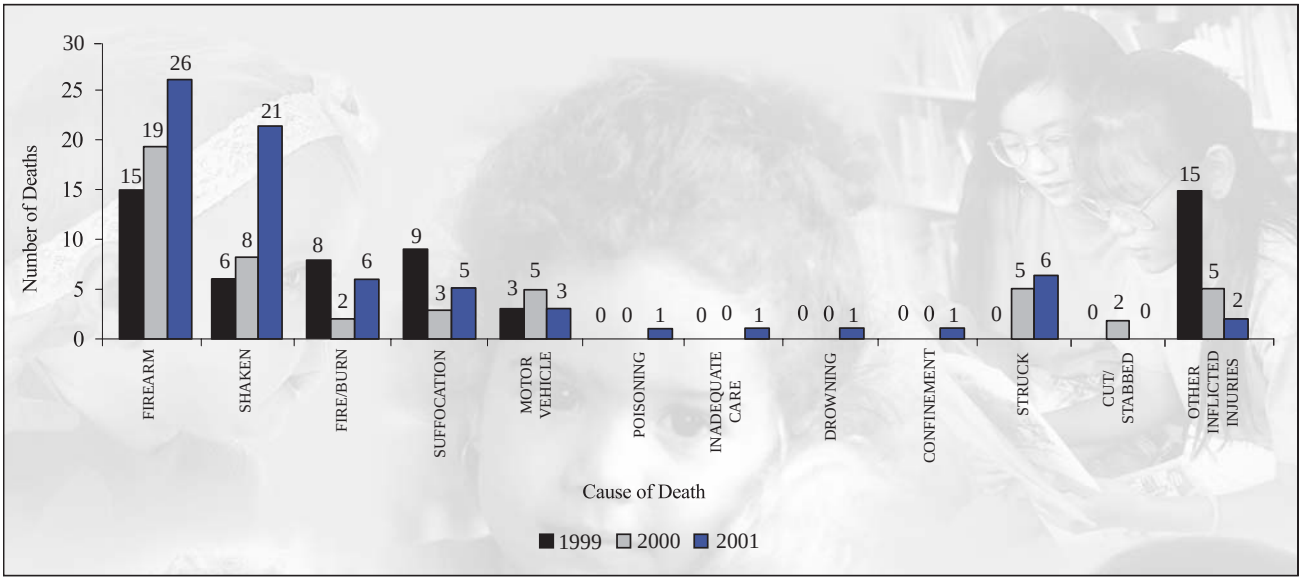


Figure 31. Homicides by Sex and Race

Sex	1999	2000	2001
Female	24	19	27
Male	32	30	46
	56	49	73

Race	1999	2000	2001
White	18	22	29
Black	27	26	44
Other	1	1	0
	56	49	73

Figure 32. Homicides by Cause



Intentional Firearm Fatalities

Of the 73 child homicides in Missouri in 2001, intentional firearm injuries resulted in the deaths of 26 children, representing 36% of all homicide deaths.

Representative Cases:

- **The increased availability of guns and drugs contributes to violence.**

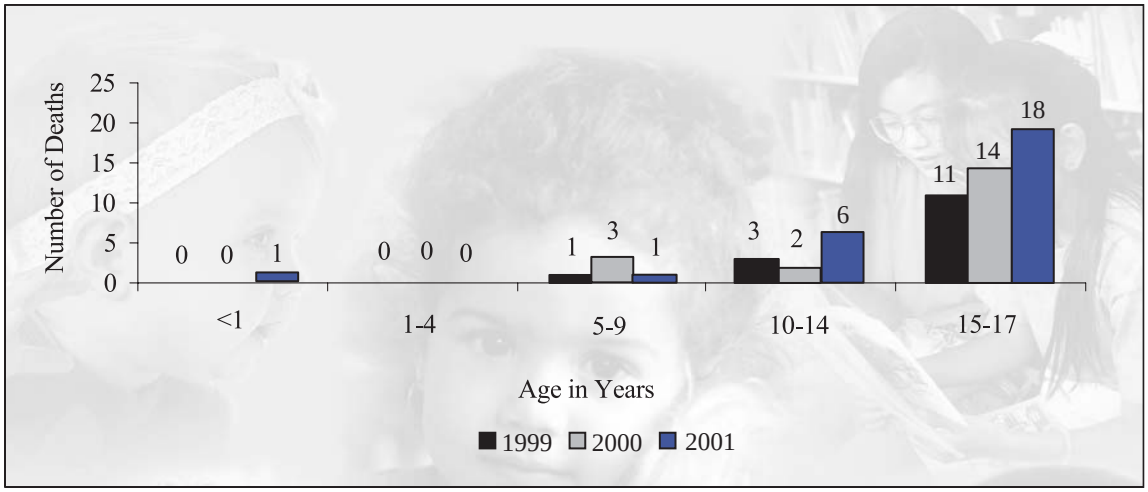
  A 16-year-old boy was found dead in a courtyard behind his apartment building. He was the victim of a gang shooting.

  A 17-year-old male was the victim of a road-rage shooting. The driver of the car pulled along side the victim and opened fire. The victim died of gunshot wounds to the head and chest.

- **Even trivial disputes can end in death when guns are involved.**

  A 15-year-old female was fatally shot in the head outside a convenience store. She had started an argument with another girl inside the store and had been shot while attempting to leave.

Figure 33. Homicide Firearm Deaths by Age



Black males continue to be at disproportionate risk.

Figure 34. Homicide Firearm Deaths by Sex and Race

Sex	1999	2000	2001
Female	3	4	4
Male	12	15	22
	15	19	26

Race	1999	2000	2001
White	2	5	5
Black	13	13	21
Other	0	1	0
	15	19	26

Youth homicide:

In 2001, **thirty-two** Missouri children were killed by non-caretakers; the vast majority of victims were adolescents. Most youth homicides involved juvenile crime and violence or abductions by adults or adolescents that culminated in murder.

Homicides, Drug or Gang Related		Homicides, Other	
Intentional firearm	22	Abductions culminating in murder by asphyxia	2
Arson	4	Child abductions by adult perpetrator, culminating in murder	2
Other inflicted trauma	1	Child murdered by adult in the home not in charge of the child	1

The most common mechanism of juvenile homicide is firearms, particularly inexpensive, readily available handguns. **Twenty-two** Missouri youth died of intentional firearm injuries in 2001; two of those were shot while committing robberies. Youth homicides are a serious problem in large urban areas, especially among black males. The majority of gun homicides occurred in the metropolitan areas of St. Louis and Kansas City. The number of firearm homicides among Missouri adolescents has risen sharply in the last three years, particularly when drug and gang activity is a factor. Other factors known to contribute to youth homicide include poverty, easy access to firearms, family disruption and school failure.

Nationally, the rate of juvenile arrests for violent crime has risen sharply since the mid-1980's. Over the next 10 years (1985-1994), juvenile arrests for murder, robbery, motor vehicle theft and weapons violations far surpassed the growth in adult arrests for these crimes. The growth in juvenile homicides has been particularly disturbing. The rapid rise of gun homicides of youth coincided with the growth of crack cocaine markets in the inner city. The increased availability of guns to youth has been matched by an increased willingness to use violence to achieve one's goals. Violent confrontations are common in adolescence. If both parties are armed, the one who acts first usually gains a decided advantage. The realization that many youth on the street are carrying a weapon increases the potential for an immediate and exaggerated response to real or perceived threats. Young males commit the majority of juvenile crime and violence. With the exception of rape and domestic violence, males are also more likely to be victims of violence than females. By age 17, the risk of homicide among males is five times that of females.

"It is important to keep the problem of youth violence in perspective...The current portrait of youth presented by the media is not grounded in statistical reality. The vast majority of young people do not carry weapons, do not deal drugs, do not join gangs and do not victimize their friends or neighborhoods...Most young people, like most adults, want nothing more than to lead their lives in peace."

-Harborview Injury Prevention and Research Center

"The causes of violence are many. The multi-faceted nature of violence almost invariably frustrates simplistic approaches to the problem. Youth violence can be prevented, but efforts must start at an early age and be sustained over time. Early childhood experiences, the nature of a child's family, the influence of peers, the neighborhood and society are keys to solving the puzzle." (*Harborview Injury Prevention and Research Center*)

Promising Approaches:

Individuals and organizations working to prevent firearm violence, choose and develop strategies that are specifically appropriate for them to use, depending on what aspect of the problem they would like to address. Interventions can be categorized into three basic types: educational, legal and technological/environmental.

- *Educational programs* are often carried out in the schools, community-based organizations and physicians' offices. They emphasize prevention of weapon misuse, the risks involved with possession of a firearm, and the need for conflict resolution and anger management skills.
- *Legal measures* strive to limit access to firearms-the number and type of people eligible to own or possess firearms, as well as the types of firearms that can be manufactured, owned and carried.
- *Technological/environmental interventions*: Firearm design requirements are both a technological and a legal intervention. Environmental and technological measures are based on the premise that automatic protections are more effective than those requiring specific action by individuals.

Violence Prevention Recommendations:

For parents:

- Provide supervision, support and constructive activity for children and adolescents in your household.
- Access family therapy and parenting assistance, as necessary, for help with anger management skills, self-esteem and school problems.

For community leaders and policy makers:

- Support the implementation of violence prevention initiatives.
- Encourage programs that provide support, education and activities for youth.
- Support legislation that restricts access to guns by children and adolescents.

For professionals:

- Support and implement crisis interventions and conflict resolution programs within the schools.

For Child Fatality Review Panels:

- Ensure that support for victims and survivors of youth violence is available.
- Support proactive approaches to crime control, especially those programs that include efforts to confiscate illegally carried firearms.

Resources and Links:

National Center for Injury Prevention and Control . . . . . www.cdc.gov/ncipc

Harborview Injury Prevention and Research Center. . . . . http://depts.washington.edu/hiprc

US Department of Justice, *The Guide for Implementing the Comprehensive Strategy for Serious, Violent and Chronic Juvenile Offenders,* Office of Juvenile Justice and Delinquency Prevention . . . . . http://research.marshfieldclinic.org/children

The National Youth Violence Prevention Resource Center. . . . . www.safeyouth.org

Fatal Child Abuse and Neglect

Of the 73 child homicides in Missouri in 2001, 38 (52%) children died at the hands of a parent or caretaker. Three of these children (8%) died of conditions of neglect. The remaining 35 (92%) died of inflicted injuries.

"In the little world in which children have their existence, Whosoever brings them up, There is nothing so finely preserved and so finely felt as injustice."

-Charles Dickens, from Great Expectations

Representative Cases:

- **Young children are more likely to die from abuse and neglect.**

  A 4-month-old male died after being repeatedly struck and thrown by his mother's paramour. Autopsy revealed multiple skull, rib and extremity fractures as well as old healing injuries.

- **Multi-disciplinary teams should be developed, supported and trained on the local level to investigate serious offenses against children.**

  A 13-month-old male died as a result of being squeezed repeatedly, resulting in clavicle and tibia fractures and a collapsed bowel. There was a history of child abuse and neglect in the household. The mother was arrested and charged with felony child abuse.

- **Parents and caretakers must be educated about the dangers of shaking and ways to cope with crying infants.**

  A 3-month-old male died after being shaken and thrown against the wall by his child care provider. The infant had been crying for at least 30 minutes prior to the incident. The childcare provider was charged with felony child abuse, murder and 19 counts of child endangerment.

  A 2-year-old male died after being shaken by his mother's paramour. The mother and numerous other family members were aware of the continued abuse by the boyfriend, but they had not reported any of their concerns.

"The loss to our society from child maltreatment is enormous. For those who survive, its victims are less likely to complete school and more likely to be unemployed or underemployed. They are more often arrested for juvenile and adult crimes. The annual economic cost of child maltreatment and its consequences in the United States is conservatively estimated at $94 billion." *(American Humane Association)*

"Murder is no less a crime because a child, rather than an adult, is the victim."

-Unknown

Child fatalities are the most tragic consequence of child abuse and neglect. In the United States, approximately 1,200 children die of abuse or neglect each year, according to vital records (NCANDS). However, it is well documented that child abuse and neglect fatalities are underreported and that, nationally, at least 2000 children die each year at the hands of their parents or caretakers. Some estimates are as high as 3-5,000. (Ewigman et al., 1993; Herman-Giddens et al., 1999) There are a number of reasons for the discrepancies and some of the fundamental problems are highlighted in this section. The Centers for Disease Control has funded an effort to develop a standardized national surveillance system capable of accurately reporting child abuse and neglect fatalities. On a state level, properly organized and functioning child fatality review systems have improved the accuracy of child death reporting.

In Missouri, there are three entities within state government responsible for child fatality information: **Department of Health & Senior Services Bureau of Vital Statistics, Department of Social Services, Division of Family Services** and the **Child Fatality Review Program.** All three exchange and match child fatality data in order to ensure accuracy throughout the system. However, the Bureau of Vital Statistics, Division of Family Services and the Child Fatality Review Program serve very different functions and, therefore, different classifications and timing periods apply when child fatality data is reported.

Vital Statistics and Death Certificate Information

The death certificate is used for two major purposes. One is to serve as legal documentation that a specific individual has died. In general, the death certificate serves as legal proof that death has occurred, but not as legal proof of the cause of death. The second major purpose of the death certificate is to provide information for mortality statistics that may be used to assess the nation's health, causes of morbidity and mortality, and developing priorities for funding and programs that involve public health and safety issues.

Death certificate information is widely recognized as inadequate as a single source for identification of child abuse and neglect deaths. Misidentification of deaths may occur because of inadequate scene investigation or autopsy procedure, inadequate investigation by law enforcement or child protection, or misdiagnosis by a physician or coroner. Child abuse/neglect fatalities often mimic illness and accidents. Neglect deaths are particularly difficult to identify because negligent treatment often results in illness and infection that can be attributed to natural causes.

Division of Family Services: Child Abuse/Neglect Fatalities

In Missouri, the Division of Family Services is the hub of the child protection community. Since August 2000, all child deaths are reported to the Division of Family Services Central Registry. Any child not dying from natural causes, while under medical care for an established natural disease, is brought to the attention of the division by the coroner or medical examiner. A fatality report is taken and, when appropriate, the report is accepted for investigation of child abuse/neglect by the division. The Child Fatality Review Program is immediately notified of all fatality reports. The division is also responsible, if ordered by a judge, for protecting any other children in the household until the investigation is complete and their safety can be assured.

After a report of child abuse or neglect has been made, investigations that return sufficient evidence supporting the report are classified as *probable cause child abuse and neglect.* When there is probable cause to believe that a child who has died was abused or neglected, or when this finding is court-adjudicated, that death is considered by the division to be a *probable cause child abuse/neglect fatality.* Thus, reports classified by the division as *probable cause child abuse/neglect fatalities* include deceased children whose deaths may or may not have been a direct result of the abuse or neglect. (An example would be a young child, allowed to cross a highway alone, who was struck by a vehicle and died of blunt trauma injuries. That death was included as a pedestrian fatality in this CFRP Annual Report, with Inadequate Care as a contributing factor. DFS determined that there was probable cause to believe that this child was a victim of neglect, specifically, lack of supervision.)

The Missouri Child Fatality Review Program: Fatal Child Child Abuse and Neglect

Child fatalities represent the extreme of all issues that have a negative impact on children. Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the late-1980's, Missouri researchers discovered that many fatal child injury cases were inadequately investigated and that many children were dying from common household hazards with inadequate supervision. Many cases of fatal abuse and neglect went undetected, misclassified as natural deaths, accidents or suicides. The information necessary for a thorough investigation of a child death was distributed among agencies, which could not share records. In 1992 Missouri initiated a comprehensive, statewide child fatality review system. The CFRP review process has resulted in better investigations, more timely communication, improved training and technical assistance, and standardized data collection that allows us to understand much more about how our children die, the circumstances in which they die and who may be responsible.

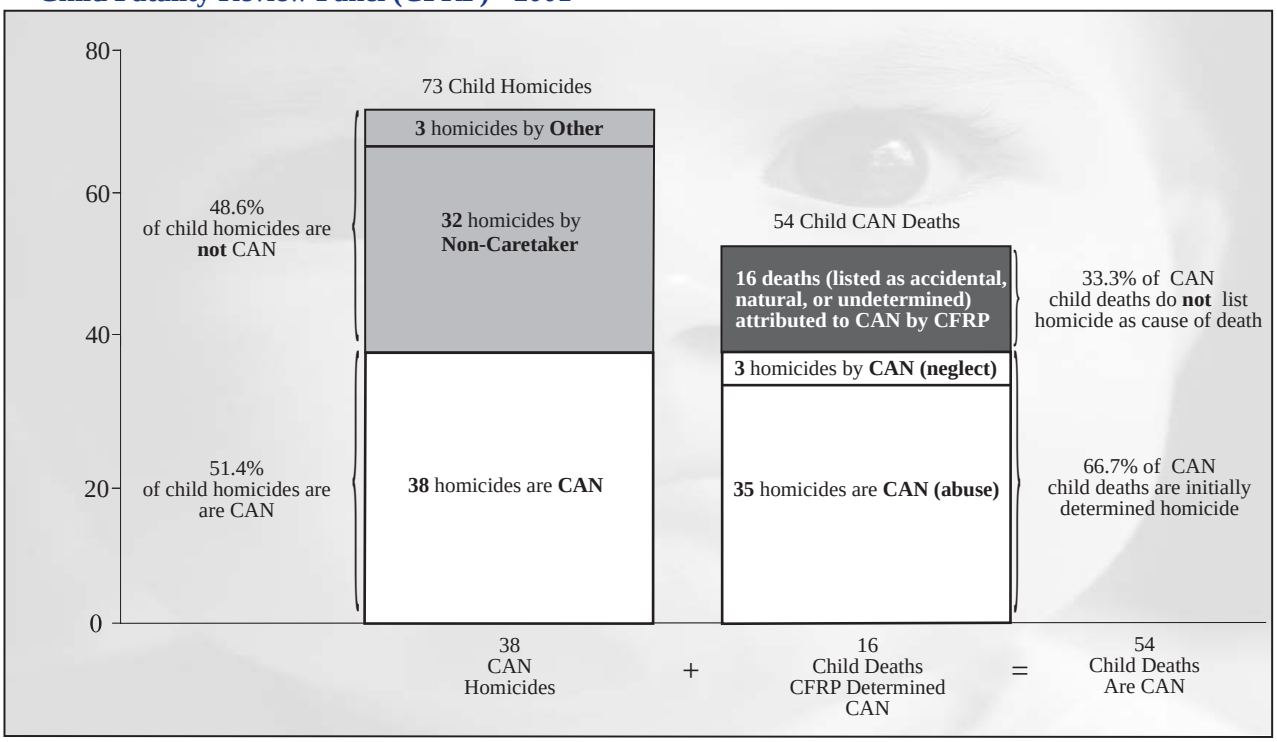
The Child Fatality Review Program annual reports for 1999 and 2000 refined the reporting and analysis of CFRP data in many ways, including an examination of data concerning "Fatal Child Abuse and Neglect." Those numbers represented a subset of child fatalities reported as *homicide* by death certificate. These changes allowed us to begin to understand much more about how Missouri children die, the circumstances in which they die and who may be responsible.

The Child Fatality Review Program defines *Fatal Child Abuse and Neglect* as child deaths resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent. This number includes, but is no longer limited to, children whose deaths were reported as homicide by death certificate; their death certificate manners of death may include natural, accident or undetermined (see Appendices 6 and 7 for additional information).

In 2001, **54** Missouri children died of Fatal Child Abuse and Neglect: **35** suffered Fatal Inflicted Injuries and **19** children were identified as victims of Grossly Negligent Treatment.

Fatal Child Abuse and Neglect: Inflicted Injury

Child Abuse/Neglect (CAN)
Child Fatality Review Panel (CFRP) - 2001



In the United States, the majority of fatal inflicted injury deaths among children result from abusive head trauma, commonly known as Shaken Baby Syndrome (SBS). In Missouri in 2001, **21** (60%) of the **35** children who died from inflicted injury at the hands of a parent or caretaker were victims of abusive head trauma (SBS).

The next most common type of physical abuse deaths involve punching or kicking the abdomen, resulting in massive internal injuries and bleeding. Infants and young children are especially vulnerable because vital organs are in close proximity with each other; the ribs are small and cannot protect vital internal organs. In 2001, **14** (40%) Missouri children died of various inflicted injuries that include punching, kicking or throwing (**5**), suffocation (**2**), fire/burn (**2**), firearm (**4**) and carbon monoxide (**1**). (Two children were shot by their mother, who then turned the gun on herself. Another child and mother died in a murder/suicide event using carbon monoxide.)

Child Abuse & Neglect Fatalities by Age	
<1 year	14
1 - 4 years	13
5 - 9 years	5
10 - 14 years	5
15 - 17 years	1

Child Abuse & Neglect Fatalities by Race and Sex			
Females	14	White	23
Males	24	Black	15

Child Abuse & Neglect Fatalities by Cause			
Firearm	4	Confinement	1
Fire / Burn	2	Drowning	1
Withhold of fluids and food from a totally dependant CP patient	1	Suffocation	2
Other physical injury (includes blunt force trauma resulting from striking or throwing)	5	Poisoning	1
		Shaken	21

Shaken Baby Syndrome

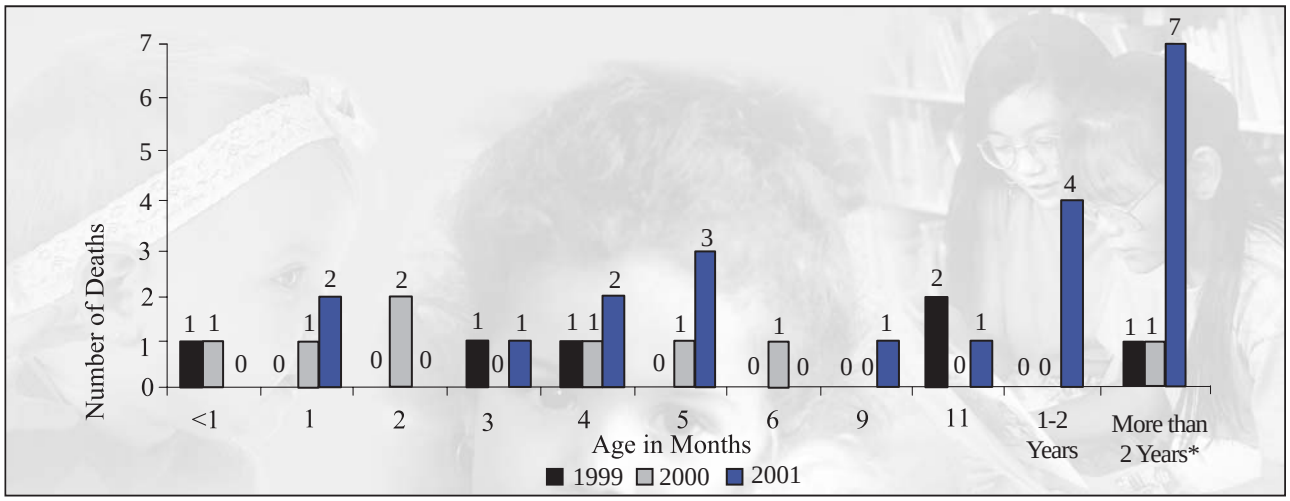
The most common mechanism of child abuse fatalities in the United States is abusive head trauma or Shaken Baby Syndrome (SBS), which involves the violent shaking of an infant or young child, usually under the age of 4 years. Babies' heads are large and heavy in proportion to their total body weight and their neck muscles are too weak to support such a disproportionately large head. Because a baby's brain is immature, it is more easily injured. When an infant or young child is violently shaken, the head rotates wildly on the axis of the neck, resulting in rotation of the brain within the skull. Brain tissue is bruised or destroyed.

Shaken Baby Syndrome involves an *extremely violent* act. Age-appropriate play, gentle shaking to awaken an unconscious child and CPR do not cause the massive destruction seen in Shaken Baby Syndrome. Short falls from sofas, beds and changing tables, and falls associated with the caretaker falling while carrying the child, do not produce the severe brain injuries of Shaken Baby Syndrome.

Immediate consequences include a decreased level of consciousness and seizures; breathing may stop; the heart may stop and the baby may die. Shaken Baby Syndrome is so lethal that 20-25% of SBS victims die of their injuries. Long term consequences for survivors may include physical disabilities, blindness, speech disabilities, seizures, learning disabilities and death. For survivors, research has established that a significant number of SBS cases are unrecognized and underreported.

Of the **35** Missouri children who died of fatal inflicted injury in 2001, **21** (60%) were victims of Shaken Baby Syndrome.

Figure 35. Shaken Baby Syndrome Deaths by Age



Note: In 1999, one child is not included in this chart. Although the cause of death was SBS, the child was 9 years old.
*Includes "late deaths" of children who were shaken as infants or toddlers.

Figure 36. Shaken Baby Syndrome Deaths by Sex and Race

Sex	1999	2000	2001
Female	3	2	15
Male	3	6	6
	6	8	21

Race	1999	2000	2001
White	3	5	13
Black	3	3	8
	6	8	21

Deliberate shaking of an infant or young child is usually the result of frustration or anger. This occurs most often when the baby won't stop crying. Other triggering events include toilet training difficulties and feeding problems.

Figure 37. Shaken/Impact Syndrome Deaths by Cause

Cause	Number of Deaths
Crying	9
Toilet Training	3
Other	2
Unknown	7
	21

Perpetrators of Shaken Baby Syndrome can be anyone. Most individuals who shake infants do not fall into a specific category, yet research shows that certain characteristics make a person more at risk of being a perpetrator. For example, research has established that fathers and other male caretakers are the most frequent perpetrators of SBS. **Twelve** (57%) perpetrators of fatal SBS in 2001 were fathers and other male caretakers.

Figure 38. Perpetrators of Shaken/Impact Syndrome Deaths

Perpetrator	Number of Deaths
Father	6
Mother	3
Stepfather	1
Mother's Paramour	4
Foster Parents (Female)	2
Child Care Worker	2
Other Child (13 yrs boy)	1
Unknown	2
	21

Fatal Child Abuse and Neglect: Negligent Treatment

Negligent treatment of a child is an act of omission, which is often fatal when due to grossly inadequate physical protection or withholding nutrition or health care necessary to preserve life. Child deaths resulting from grossly negligent treatment are frequently difficult to identify because neglect often results in illnesses and infections that can be attributed to natural causes or exposure to hostile environments or circumstances that result in fatal "accidents."

Definitions of negligent treatment vary depending on whether one takes a legal, medical, psychological, social service or lay perspective. There are broad, widely recognized categories of neglect that include: *physical neglect, emotional neglect, medical neglect, neglect of mental health, and educational neglect.* Within those definitions, there are subsets, as well as variations in severity that often include *severe* or *"nearly-fatal"* and *fatal*. Negligent treatment may or may not be intentional; however, the end result for the child is the same whether the parent is willfully neglectful (e.g. out of hostility) or neglectful due to factors such as ignorance, depression or overwhelming stress and inadequate support.

Grossly Negligent Treatment

Grossly negligent treatment by a parent or caretaker generally involves failure to protect from harm and withholding or otherwise failing to provide food, shelter, or medical care necessary to meet the child's basic needs. This level of negligence is egregious and surpasses momentary inattention or a temporary condition; it is often part of a pattern of negligent treatment. Child deaths often result when a parent or caretaker fails to inadequately supervise the child, usually for extended periods of time.

In some cases, "failure to protect from harm" or failure to meet basic needs involves exposure to a hostile environment or a hazardous situation with potential for serious injury or death. An example would be a mother who allowed her young child to ride in a vehicle with a driver who was known to be drunk. Another example is a toddler, left alone in a parked vehicle for over an hour, who died as a result of exposure to excessive heat.

Medical neglect, as a form of grossly negligent treatment, refers to failure to provide prescribed medical treatment or emergency medical care for a known illness or injury with potential for a serious or fatal outcome. Examples include untreated diabetes or asthma.

In 2001, **19** Missouri were identified by the Child Fatality Review Program as victims of grossly negligent treatment that resulted in death.* Circumstances of grossly negligent treatment include the following:

Children left unattended in and around motor vehicles, (all <3 years of age) resulting in exposure to excessive heat.	7
Children left unattended in home for an extended period of time died of suffocation by entrapment	3
Malnutrition/failure to thrive in an infant	1
Starvation of a handicapped child	1
Dehydration in an infant, due to heat exposure/unsanitary living conditions	1
Motor vehicle fatalities in which the child was allowed to ride with an adult, who was known to be drunk	2
Victim of chronic neglect and lack of supervision, mauled by dogs	1
Bathtub drowning that occurred while mother was under the influence of methamphetamine/withholding of emergency medical care	1
Medical neglect/withholding medical treatment for known, potentially fatal disease	2

*Note that, for data purposes, 16 of the 19 deaths listed were not designated as homicide by death certificate; they are included in the data for the appropriate Illness/Natural Cause or Unintentional Injury category, according to the cause and circumstances. it should also be noted that this group of children was not included in Fatal Child Abuse and Neglect totals in previous CFRP Annual Reports.

Prevention Recommendations:

For parents:

- Report child abuse and neglect.
- Seek crisis help through the Parent Helpline (800-367-2543) or ParentLink (800-552-8522).

For community leaders and policy makers:

- Support and fund home-visitation child abuse prevention programs that assist parents.
- Enact and enforce laws that punish those who harm children.

For professionals:

- Support and facilitate public education programs that target male caretakers and child care providers.
- Expand training on recognition and reporting of child abuse and neglect.
- Support development and training for multidisciplinary teams to investigate child abuse.

For Child Fatality Review Panels:

- The role of CFRP panels is critical in identifying fatal child abuse, protecting surviving children, and ensuring that the family receives appropriate services. CFRP panels provide important data that enhances our ability to identify those children who are most likely to be abused and intervene before they are harmed.

Resources and Links:

National Committee to Prevent Child Abuse . . . . . .www.childabuse.org

American Academy of Pediatrics . . . . . .www.aap.org

Harborview Injury Prevention and Research Center . . . . . .http://depts.washington.edu/hiprc

Missouri Children's Trust Fund
(Missouri's Foundation for Child Abuse Prevention) www.ctf4kids.org

The National Center on Shaken Baby Syndrome . . . . . .www.dontshake.com

U.S. Department of Justice,
Office of Juvenile Justice and Delinquency Prevention . . .www.ojjdp.ncjrs.org

ChildAbuse.com . . . . . .www.childabuse.com

Suicides

Suicide was the manner of death of 23 Missouri children in 2001.

Representative Cases:

- **Parents and professionals responsible for children must be educated to recognize and respond to risk factors for suicide.**

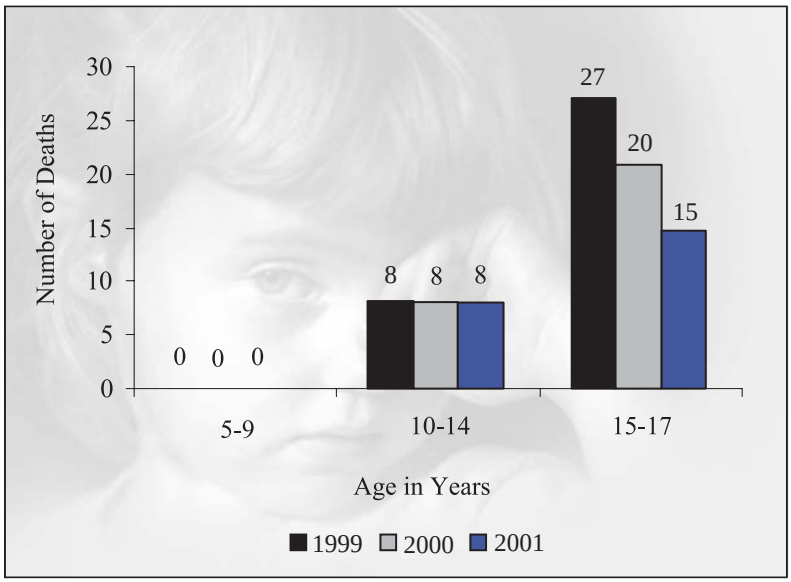
  A 14-year-old male with prior mental health issues shot himself with a .22 caliber rifle in his bathroom. He had a lengthy history with the local juvenile office because of his behavior problems.

  A 13-year-old female with a past medical history of depression was found dead after overdosing on a prescription drug. Upon autopsy, there was evidence of several prior attempts and self-mutilation.

  A 16-year-old male, who had recently broken up with his girlfriend shot himself with a pistol while on the phone with her. He had no prior history and had not talked of suicide. A note was found at the scene.

In Missouri and the United States, suicide is the third leading cause of death for young people following unintentional injuries and homicides. The suicide rate among young teens and young adults increased by more than 300% in the last three decades and rates continue to remain high. In Missouri in 2001, **23** children died of self-inflicted injury; **15** were age 15-17; the remaining **8** were children age 10-14.

Figure 39. Suicides by Age



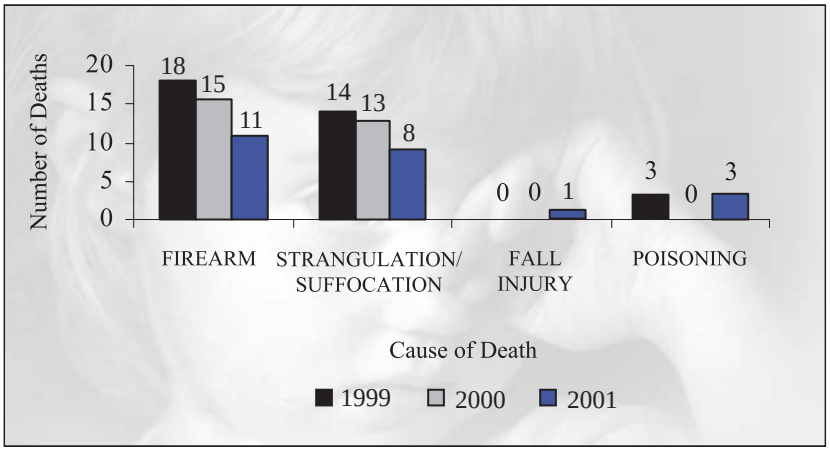
White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

Figure 40. Suicides by Sex and Race

Sex	1999	2000	2001
Female	9	4	3
Male	26	24	20
	35	28	23

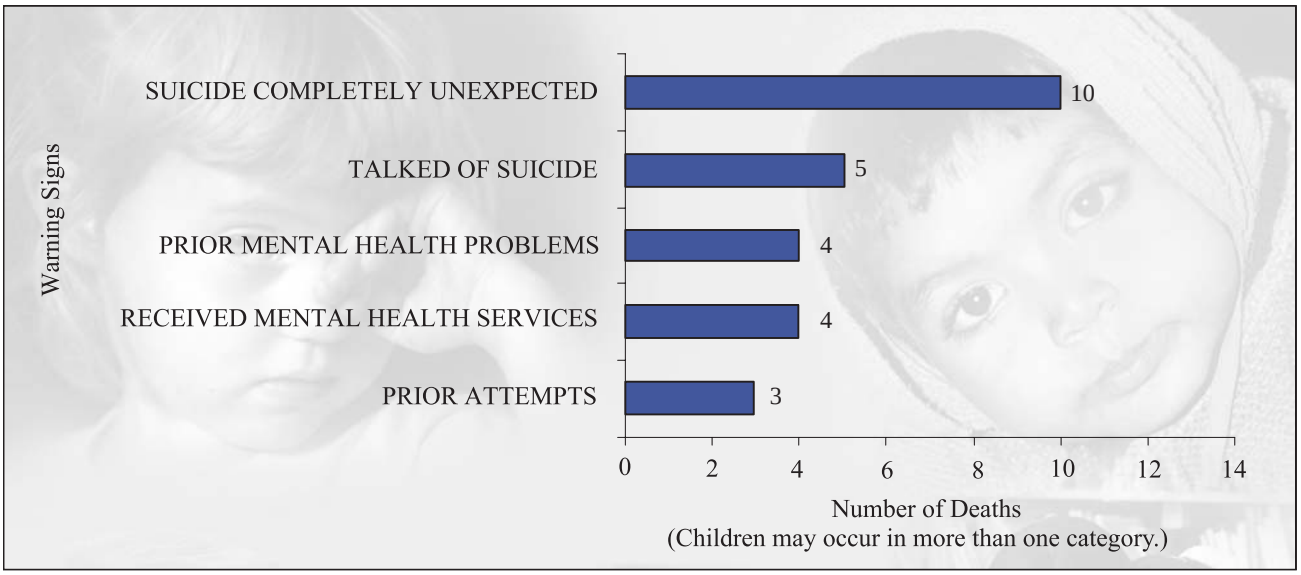
Race	1999	2000	2001
White	31	24	18
Black	4	4	5
	35	28	23

Figure 41. Suicides by Mechanism



Firearms and suffocation/strangulation are the most common mechanisms of suicide among Missouri children.

Figure 42. 2001 Warning Signs of Suicide



Of the **23** suicide victims age 17 and under, **10** (43%) had displayed one or more warning signs.

Preventing youth suicide:

Suicidal behaviors in young people are usually the result of a process that involves multiple social, economic, familial and individual risk factors, with mental health problems playing an important part in its development. Identified risk factors for suicide and attempted suicide for young people include: mood disorders, substance abuse, certain personality disorders, low socioeconomic status, childhood maltreatment, parental separation or divorce, inappropriate access to firearms and interpersonal conflicts or losses. Only a few studies have examined protective factors among youth for suicidal behavior. Both parent-family connectedness and perceived school connectedness have been shown to be protective against suicidal behavior.

A Summary of Suicide Risk and Protective Factors (Youth and Young Adults)

Suicidal behavior emerges out of a complex and dynamic interplay between an array of individual, social and environmental risk and protective factors. While we know that those at greatest risk are single, young (15-24), Caucasian and aboriginal males, suffering from major depression and substance abuse with easy access of firearms, the reality is that many young people who kill themselves do not fit this statistically determined profile. The chart on the next page summarizes some of the most well known risk/protective factors. Note that it is not an exhaustive list.

The chart is from “Best Practices in Youth Suicide Prevention”, developed by the Suicide Prevention Information and Resource Centre (SPIRC) of British Columbia Faculty of Medicine, UBC; 2250 Westbrook Mall, Vancouver, BC, Canada V6T 1W6; email: spirc@interchange.ubc.ca; a more complete discussion can be found in a subsequent document developed by SPIRC: “Practice Principles: A Guide for Mental Health Clinicians Working With Suicidal Children and Youth” www.mcf.gov.bc.ca/youth/suicid_%20prev_manual.pdf

Key Context	Predisposing Factors	Contributing Factors	Precipitating Factors	Protective Factors
Individual	• Previous attempt • Depression/Psychiatric disorder • Prolonged or unresolved grief	• Rigid cognitive skills • Poor coping skills • Substance abuse • Sexual orientation issues • Impulsitivity • Hypersensitivity	• Personal failure • Humiliation • Individual trauma • Developmental crisis	• Easy temperament • Creative problem-solving • Personal autonomy • Previous experience with self-mastery • Optimistic outlook • Sense of humor
Family	• Family history of suicidal behavior/ completed suicide • Family violence/abuse • Family history of psychiatric disorder • Early childhood loss/ separation • Social isolation & alienation	• Substance abuse within family • Family instability • Ongoing conflict	• Loss of significant family member • Death, especially by suicide	• Family relationships characterized by warmth & belonging • Adults modeling healthy adjustment • High & realistic expectations
Peers	• Social isolation & alienation	• Negative youth attitudes toward adult assistance	• Teasing/cruelty • Interpersonal loss • Rejection • Death, especially by suicide	• Social competence • Healthy peer modeling • Acceptance & support
School	• Long-standing history of negative school experience • Lack of meaningful connection to school	• Disruption during key transitional periods at school • Reluctance/uncertainty about how to help among school staff	• Failure • Expulsion • Disciplinary crisis	• Presence of adults who believe in them • Parent involvement • Encouragement of participation
Community	• Community “legacy” of suicide • Community marginalization • Political disempowerment	• Sensational media portrayal of suicide • Access to firearms or other lethal methods • Reluctance/uncertainty about how to help among key gatekeepers • Inaccessible community resources • Economic deprivation	• High profile/celebrity death, especially by suicide • Conflict with the law/ incarceration	• Opportunities for participation • Evidence of hope for the future • Community self determination & solidarity • Availability of resources

Prevention Recommendations:

For parents:

- Seek early treatment for children with behavioral problems, possible mental disorders (particularly depression and impulse-control disorders) and substance abuse problems.
- Limit young people's access to lethal means of suicide, particularly firearms.

For community leaders and policy makers:

- Encourage health insurance plans to cover mental health and substance abuse on the level physical illnesses are covered.
- Support and implement school and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse and aggressive behaviors.
- Enact and enforce laws and policies that limit young people's access to firearms and encourages responsible firearms ownership.

For professionals:

- Children who have attempted suicide or displayed other warning signs should receive aggressive treatment attention.

For Child Fatality Review Panels:

- Support or facilitate evidence-based suicide prevention programs in your community.
- In reviewing a possible suicide, consider carefully the warning signs and history of the victim. Consider, also, points of early intervention that can be enhanced in your community to prevent other suicides and suicidal behaviors.

Resources and Links:

National Strategy for Suicide Prevention . . . . . .www.mentalhealth.org/suicideprevention

American Association of Suicidology . . . . . .www.suicidology.org

National Center for Suicide Prevention Training . . . . .www.ncspr.org